Suicide Prevention in the New York City Department of Correction

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Like other cities and counties around the nation, New York City is coping with huge increases in its jail population and with corresponding increases in the number of individuals who come to us with serious mental health problems. This article will address one of the more difficult challenges facing the NYC Department of Correction: suicide prevention.

First, I will briefly describe the NYC Department of Correction jails system and review the characteristics of the inmate population, in particular their mental health problems. I will then describe the system, programs, and policies that have been established to serve and manage mentally ill inmates in the NYC jails. In particular, I will highlight a unique suicide prevention initiative, the "Inmate Observation Aide Program." Finally, I will conclude with some ideas for enhancing mental health care in your jails.

Characteristics of the Inmate Population

The New York City Department of Correction is responsible for administering seventeen jails. Today, as usual, these facilities are operating at over 100 percent of capacity, with more than 20,000 individuals in custody. We experience rapid inmate turnover: over 115,000 individuals are admitted to our custody each year, with an average length of stay of sixty-seven days. More than 65 percent of the inmates in the system are pretrial or presentence detainees.

The individuals remanded to our custody have many programming needs. Several facts about the makeup of our population are critical to understanding the problems involved in serving our inmates:

- 57 percent are black, 33 percent are Hispanic, 9 percent are white, and 1 percent are other.
- 82 percent are male.
- 10 percent speak a primary language other than English.
- 60 percent read below a fourth grade level.
- 83 percent am unemployed at arrest and lack job readiness skills.
- 39 percent were raised by one parent.
- 14 percent of all inmates and 23 percent of women inmates reported being abused as children.

These demographic and social characteristics define a population that requires critical services beyond those available through the mental health providers in the jails.

By the time offenders with mental illness and substance abuse problems reach the jail with its stresses and crowding, they are truly individuals in crisis.

Over the past several years, the crack epidemic has only exacerbated this need for comprehensive services. In New York, we are seeing the consequences among the inmates in our facilities:

- 85 percent of inmates surveyed in August 1991 reported using drugs at least once a week prior to arrest; 60 percent reported use of more than one drug prior to arrest.
- 74 percent of those given urine tests in Manhattan central booking tested positive for cocaine.
- Over 18,000 inmates per year receive methadone detoxification.
- The city Department of Health estimates that 50 percent of the inmate population has a history of intravenous drug use, and a recent blind seropositive study of inmates indicated that 26 percent of women and 16 percent of men were HIV-positive.

These statistics illustrate some of the grave problems facing individuals in our custody. I would like to focus here on their mental health needs.

Mental Health Needs in NYC Jails
Since 1986, the number of new admissions referred for mental health evaluation has risen from 21 percent to over 25 percent. According to our health care providers:

- 38 percent of new admissions have a history of suicidal threats.
- 20 percent currently evidence suicidal ideation.
- 45 percent have severe personality disorder.
- 10 percent experience auditory and visual hallucinations.
- 11 percent evidence paranoid ideation.
- 56 percent have significant depressive feelings.
- 11 percent are concerned about self-mutilation.

By the time inmates with these levels of mental illness-exacerbated by substance abuse problems-reach the jail with its stresses and crowding, they are truly individuals in crisis.

Developing Systemwide Suicide Prevention Programs and Policies

Two key factors have enabled the system to respond effectively to the mental health needs of inmates, particularly those who are suicidal: an interdepartmental emphasis on standards, and the availability of funding.

In the late 1970s and early 1980s, more than eighty inmates had taken their lives in New York City correctional facilities. The NYC Department of Correction, the Department of Health, the Department of Mental Health, Mental Retardation and Alcoholism Services, and the Health and Hospital Corporation made a serious commitment to reduce the number of suicides among the inmate population.

In 1985 the Board of Correction, an oversight agency, promulgated a comprehensive set of mental health minimum standards that established a range of services and served as an impetus for change. The standards institutionalized policies and procedures that these agencies were already following or planned to initiate. Because of the standards, funding was appropriated to increase mental health staffing and provide mental health training for custodial staff assigned to mental health housing areas.

City Health Department Components
By City Charter, the New York City Department of Health has overall responsibility for the delivery of health care to inmates. Mental health services are provided in every jail, either directly by the Department of Health/Prison Health services or through contracts with vendors.

The staff consists of psychiatrists, psychologists, social workers, and other treatment staff who provide crisis intervention, suicide prevention, therapeutic counseling, and medication services. While the primary responsibility of the mental health program is crisis intervention, particularly as it relates to suicide prevention, staff also focus on stabilizing psychotic and depressed patients. The Department of Health provides three levels of mental health care:

- **Outpatient services** are provided for the general population, including inmates with minimal mental disturbance who can function without medication or who requite only short-term medication for stabilization.
- **Mental observation beds are** maintained for inmates who are suicidal, unable to function safely in a general population area, or need medication more than once a day. These inmates are seen on daily rounds by non-psychiatric clinical staff and are scheduled for weekly visits with a psychiatrist. Those who evidence continued suicidal ideation or who have a history of suicidal behavior are observed more closely. Mental observation units vary in size from thirty to fifty beds in either single-cell or dormitory housing, for a total capacity of 549.
- **The Mental Health Center** has a capacity of 189 beds and provides twenty-four-hour subacute psychi-

atric and nursing coverage. All patients are seen on multiple daily rounds by both psychiatric and general clinical staff. Emphasis is placed on frequent observation of patients with significant suicidal potential or other serious acting out behaviors. Individual treatment is scheduled twice weekly for those requiring enhanced suicide watch.

Municipal hospital forensic units are available for inmates whose condition deteriorates and who cannot be stabilized in the Mental Health Center, and also for those who require acute care.

Correction Department Initiatives
The Department of Correction has also initiated an array of measures to prevent inmate suicide in its jails:

- The department has designated more than 700 mental health beds for male and female inmates in the jails. These beds are provided both in single-cell housing and dormitory housing for suicidal inmates.

- The department has designated "Enhanced Suicide Observation" beds in the mental health housing units. Inmates are placed in an area that allows for enhanced observation by custodial staff and specially trained Inmate Observation Aides. Special Observation logbooks are maintained, with entries required every fifteen minutes.

- The department has provided twenty-eight hours of inservice mental health training to more than 900 correctional officers and supervisors who are assigned to mental health housing units.

- The department initiated a holiday season "mental health alert" flyer to remind staff to watch for inmates who exhibit signs of suicidal behavior.

Despite significant increases in the inmate population, we have substantially lowered the number of jail suicides from eleven in 1985 to three in 1991. The decrease is a result of the departments' commitment to provide mental health treatment services and training for uniformed and civilian staff, along with the establishment of mental health observation dorms and the Inmate Observation Aide Program.

Inmate Observation Aide Program
The prevention methods discussed thus far are based on the segregation and intensive observation of inmates who have been identified as potentially suicidal. But what about those inmates who don't initially show signs and later develop suicidal tendencies?

The Inmate Observation Aide Program allows the department to intervene with and help individuals who display a potential for suicide or suffer from mental illness after making it through initial screening. The program was developed to watch over those inmates who are housed in new admissions housing, punitive segregation, administrative segregation and protective custody, the Mental Observation Housing Units, and all adolescent housing.

The Observation Aide Program, which was begun in 1982, trains staff and inmates to prevent and intervene in suicide attempts. The program is staffed by three officers and a captain, who is the program coordinator. All staff am state-certified as trainers and have received training in mental health, crisis intervention, and suicide prevention. Since 1982, the program has trained 8,500 officers, with 659 trained in 1991.

At thirteen jails, Observation Aide instructors who are correction officers conduct weekly suicide prevention training for inmates, who are employed as Observation Aides within their facilities. Observation Aide Instructors also assist in investigations of suicides and attempted suicides, and report dangerous or life-threatening conditions observed during their tours of housing areas. The instructors provide a critical service. Their successful training efforts have helped the department develop a proactive approach to saving lives.

Prior to their assignment by security, inmates participating in the Observation Aide program must be medically cleared, receive the required training, successfully pass the prescribed examination, and be certified by an Observation Aide

instructor. Training for Observation Aides is continuous. The first requirement is that all prospective aides receive and read the suicide prevention training guide. Approximately 54,000 inmates have been trained since 1982, with 8,200 trained in 1991.

Each aide is responsible for conducting six vigilant patrols per hour of an assigned area at irregular intervals. They must talk with inmates to identify their needs and promptly report any unusual or suicidal behavior to the correction officer on duty. Aides also note in the Observation Aide logbook all incidents of suicide attempts or acts of unusual behavior. When necessary, aides assist the correction officers following suicide attempts or actual suicides by, for example, holding up a hanged inmate while the officer cuts the individual down.

The NYC DOC's Inmate Observation Aide Program allows the department to intervene with and help individuals who display a potential for suicide or suffer from mental illness after making it through initial screening.

Since the implementation of CPR training for correction officers at the Correction Academy, Observation Aides are no longer required to be certified in CPR. The ultimate responsibility for the care, custody, and control of all inmates rests with the correction officer on duty, and in an emergency situation we do not want any conflict or confusion about whose responsibility it is to take action.

One of the many benefits of the Observation Aide Program is the number of inmates it employs. At any given time, approximately 700 inmates are employed by the program. Aides are paid $0.40 per hour for this job.

The actual employment is a benefit, but no more than the self-worth the aides receive from doing this type of work. The **program has helped to raise the level of self-esteem exhibited by those in the program. Positive** change in aides' attitudes and behavior has been attributed to their participation in the program. Once in the program, many of the aides view life from a different perspective; that is, they now believe that they do make a difference.

Recommendations

I would like to conclude with some ideas for improving mental health care in jails, along with steps that must be taken in the future to deal more effectively with the mentally ill. My advice to other correctional systems would be as follows:

- Establish a multi-faceted program designed to facilitate the identification, referral, and treatment of inmates who are suicidal and/or seriously mentally ill at any point during their incarceration, but particularly at high-stress points: on admission, after a court adjudication when the inmate is returned to the jail, or following the receipt of bad news regarding the offender or his or her family.
- Ensure that there are agreed-upon criteria for admission to each level of care.
- Dedicate dormitories or open wards to house suicidal inmates. If cells or rooms must be used, they should be as nearly suicide-proof as possible; that is, they should be without protrusions that an inmate can hang from, including cell vents and window knobs.
- Designate enhanced suicide watch dorm beds and cells that are the most visible to the officer.
- Establish ongoing suicide prevention/mental health training that includes CPR and first aid.
- Establish monthly meetings between facility executive staff and mental health unit chiefs to coordinate the delivery of services. Minutes should be kept of these meetings.
- Establish an Inmate Observation Aide Program.
- Be cognizant of and plan for the increased admission of inmates needing treatment for substance

abuse and its related social and psychiatric problems. You can also expect to see a greater need for suicide prevention among the growing number of HIV-positive inmates. A recent study found the suicide risk to be greater for men ages twenty-five to fifty-nine with AIDS than for a comparable group.

- Finally, you should expect to see-if you are not already seeing-HIV-positive inmates who are suffering from AIDS dementia. Who will be the primary caregiver, medical or mental health, particularly when the patient needs chronic care?

The treatment and suicide prevention services I have described are extensive. I know of no other correction system in the United States that offers such a broad range of services. Given the rapid turnover of our population, implementing these initiatives has been an especially difficult challenge. Nevertheless these programs clearly indicate our willingness to be creative and flexible in responding to the mental health needs of our inmates.

Conclusion

I would like to close with steps that I believe must be taken in the future to deal more effectively with the mentally ill in the jails.

While I believe that developing and implementing correctional strategies to deal with mentally ill inmates is important, such programs do little to "solve" the crisis. We must as a nation focus our attention on solving the societal problems that have intensified demands on jails' mental health programs. The jail is not the best place for the homeless, who present myriad social, medical, and psychiatric problems, nor for HIV-positive individuals, some of whom are beginning to present suicidal ideation and AIDS dementia. These individuals, even when arrested for a crime, cannot be adequately and appropriately treated in jail.

We continue to dedicate more money to jail and prison construction while funding for mental health substance abuse and other critical social welfare services remains limited. To an extent, this is an appropriate and necessary policy; however, imprisonment alone does not address the fundamental problems: addiction, poverty, lack of education, and social alienation.

What is needed is a much more creative range of housing, health, education, and substance abuse programs in the communities across our country. Until society decides that it cares enough to deal with mental health and substance abuse problems, we as professionals need to develop alternative proposals for treating the mentally ill more effectively and in less costly ways than warehousing them in the jails and prisons of this country.

Thank you for the opportunity to share these thoughts. I hope that this article will stimulate some of the energy and ideas that are so desperately needed.

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